Medicaid and Children's Health Insurance Program (CHIP) Provisions in America's Affordable Health Choices Act of 2009 (H.R. 3200)

September 18, 2009

Congressional Research Service
https://crsreports.congress.gov
R40821

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

The 111th Congress has devoted considerable effort to health reform that seeks to increase health insurance coverage for more Americans and help to control increasing costs, while improving quality and patient outcomes. Health reform legislation, America's Affordable Health Choices Act of 2009 (H.R. 3200), was introduced in the House on July 17, 2009, and ordered reported by the Committee on Energy and Commerce on July 31, 2009. H.R. 3200 proposes sweeping reforms of the health care delivery system, which are described in the three major components of H.R. 3200 designated Divisions A, B, and C. Division A, "Affordable Health Care Choices," focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, and providing financial assistance to certain individuals and, in some cases, small employers. Division B, "Medicare and Medicaid Improvements," proposes modifications to the largest two health insurance programs to make them consistent with the changes proposed in Division A and to amend other provisions in existing federal statute. Division C, "Public Health and Workforce Development," would amend and expand existing health professions and nursing workforce programs.

This report summarizes the 34 Medicaid provisions in Division B of H.R. 3200. Due to the breadth of the changes proposed in H.R. 3200, some provisions of Divisions A and C also could affect Medicaid, but these are not Medicaid-specific. Division B also introduces a number of technical changes intended to improve quality of care, reduce federal and state expenditures, and address coverage gaps. The Division B provisions would introduce changes or new provisions to Medicaid eligibility; benefits; financing; waste, fraud, and abuse; payments to territories; demonstrations and pilot programs; and other miscellaneous Medicaid components. A major provision in Division B would expand Medicaid eligibility for traditional and non-traditional (mostly childless adults) beneficiary categories to 133⅓% of the Federal Poverty Level. States would receive 100% federal medical assistance percentage (FMAP) matching rates for these expanded beneficiary categories for two fiscal years (FY2013-FY2014) and then 90% thereafter (FY2015 and beyond). Another eligibility expansion would permit states the option of covering extremely high prescription drug expenditures for individuals already eligible for Medicaid when their incomes exceeded customary levels. Under benefits, Medicaid programs would be required to cover preventive services, receive higher FMAP rates to cover translations or interpretation services, and tobacco cessation products would be removed from Medicaid's excluded drug list.

There are a number of financing changes that would affect Medicaid under H.R. 3200, including reducing Medicaid disproportionate share hospital (DSH) payments by $10 billion by FY2019, increasing prescription drug rebates, and extending prescription drug discounts to Medicaid-managed care enrollees. There are a number of additional waste, fraud, and abuse provisions affecting Medicaid and the Children's Health Insurance Program (CHIP). These provisions include requirements to deny payment for health care acquired conditions, require new Medicaid Integrity Program evaluations and reports, increase the amount of time states would have to repay overpayments to one year when the overpayments were due to fraud, and require states to implement a national correct coding initiative, similar to the Medicare program. Under H.R. 3200, spending caps for the territories would be increased, and a series of demonstrations would be approved for Medicaid, including a medical home program, an accountable care organization program, and a program for stabilization of emergency medical conditions by privately owned or operated mental disease institutions.

Contents

Contacts

Status of House Legislation

H.R. 3200, America's Affordable Health Choices Act of 2009, as introduced on July 14, 2009, was referred to the House Committees on Energy and Commerce, Ways and Means, Education and Labor, Oversight and Government Reform, and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned. The Committees on Education and Labor and on Ways and Means each ordered reported, as amended, their versions of H.R. 3200 on July 17, 2009. The Committee on Energy and Commerce ordered reported, as amended its version on July 31, 2009. The Committees on Oversight and Government Reform and the Budget have not taken up the legislation for consideration.

Overview of H.R. 3200

H.R. 3200 proposes sweeping reforms of the U.S. health insurance and health care system. H.R. 3200 contains three major Divisions, 18 Titles, 51 Subtitles and 284 Sections, including 34 Medicaid sections. These 356 different organizational components often are interlinked and interdependent so that provisions in one division or section are likely to affect provisions in another or several other sections.

The three major components of H.R. 3200 are designated Divisions A, B, and C. Division A, "Affordable Health Care Choices," focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, and providing financial assistance to certain individuals and, in some cases, small employers.[1] Division B, "Medicare and Medicaid Improvements," proposes modifications to the largest two health insurance programs to make them consistent with the changes proposed in Division A and to amend other provisions in existing federal statute. Division B also introduces a number of technical changes intended to improve quality of care, reduce federal and state expenditures, and address coverage gaps for both Medicare and Medicaid.[2] For Medicaid, among other major proposals, Division B would expand Medicaid eligibility for traditional and non-traditional (mostly childless adults) beneficiary categories up to 133⅓% of the Federal Poverty Level (FPL). Division C, "Public Health and Workforce Development," would amend and expand existing health professions and nursing workforce programs.[3]

Report Overview

This report provides a discussion of the Medicaid provisions contained in H.R. 3200. The discussion incorporates amendments that were adopted by the House Committee on Energy and Commerce. The report is divided into seven major categories:

- Eligibility.
- Benefits.
- Financing.

[1] For more information about Division A, see CRS Report R40724, *Private Health Insurance Provisions of H.R. 3200.*

[2] For more information about the Medicare components in Division B, see CRS Report R40804, *Medicare Program Changes in H.R. 3200, America's Affordable Health Choices Act of 2009* , coordinated by Sibyl Tilson.

[3] For more information about Division C, see CRS Report R40745, *Public Health, Workforce, Quality, and Other Provisions in H.R. 3200*, coordinated by C. Stephen Redhead.

- Waste, Fraud, and Abuse.
- Payments to Territories.
- Demonstrations and Pilot Programs.
- Miscellaneous.

Each topic contains a brief summary of existing Medicaid law and related background to provide context for the discussion of changes proposed by H.R. 3200.

Eligibility

Medicaid is a means-tested entitlement program operated by states within broad federal guidelines. To qualify, an individual must meet both categorical (i.e., must be a member of a covered group such as children, pregnant women, families with dependent children, the elderly, or the disabled) and financial eligibility requirements. Medicaid's financial requirements place limits on the maximum amount of assets and income individuals may possess to participate in Medicaid. Additional guidelines specify how states should calculate these amounts. The specific asset and income limitations that apply to each eligibility group are set through a combination of federal parameters and state definitions. Consequently, these standards vary across states, and different standards apply to different population groups within states.

Of the approximately 50 different eligibility "pathways" into Medicaid, some are mandatory while others may be covered at state option. Examples of groups that states *must* provide Medicaid to include pregnant women and children under age six with family income below 133% of the federal poverty level (FPL), and poor individuals with disabilities or poor individuals over age 64 who qualify for cash assistance under the SSI program. Examples of groups that states *may* choose to cover under Medicaid include pregnant women and infants with family income exceeding 133% FPL up to 185% FPL, and "medically needy" individuals who meet categorical requirements with income up to 133% of the maximum payment amount applicable under states' former Aid to Families with Dependent Children (AFDC) programs based on family size.[4] "Childless adults" (nonelderly adults who are not disabled, not pregnant and not parents of dependent children), for example, are generally not eligible for Medicaid, regardless of their income.

H.R. 3200 makes several changes to Medicaid eligibility. Among the provisions that would impact eligibility, the bill would add two new mandatory eligibility groups, and add two new optional eligibility groups. In addition, it would make several modifications to existing eligibility groups, and add provisions to facilitate outreach and enrollment in Medicaid, CHIP, and the Health Insurance Exchange.[5]

[4] Unlike most other eligibility groups, medical expenses (if any) may be subtracted from income in determining financial eligibility for medically needy coverage, which is often referred to as "spend down,"

[5] Similar to existing state health reform models, such as the Massachusetts Connector, the Exchange would facilitate the purchase of qualified health benefit plans by individuals and businesses. The Exchange would not be a health insurer; but would provide eligible individuals and small businesses a vehicle to shop and compare insurers' health plans. For more information on the Insurance Health Exchange, see CRS Report R40724, *Private Health Insurance Provisions of H.R. 3200*, by Hinda Chaikind et al.

Medicaid and Health Insurance Reform

Mandatory Eligibility Expansions

H.R. 3200 would add two new mandatory eligibility groups to the Medicaid statute. A new "non-traditional" group would include individuals under age 65 who are not otherwise eligible for Medicaid under existing eligibility categories (e.g., childless adults) with income up to 133⅓% of the federal poverty level as determined using methodologies and procedures specified by the Secretary of the Department of Health and Human Services (the Secretary) in consultation with the Health Choices Commissioner. (The Commissioner is primarily in charge of enforcing new private health insurance standards and would oversee the Health Insurance Exchange, as described in Sec. 142 of H.R. 3200). A new "traditional" group would include individuals under age 65 who would otherwise be eligible for Medicaid in existing eligibility categories, (e.g., children, pregnant women, families with dependent children, and those with disabilities), except they do not meet income standards in effect as of June 16, 2009. The upper income standard applicable to this new "traditional" group would also be 133⅓% of the federal poverty level.

For both the new "non-traditional" and "traditional" groups, services provided to these individuals would be fully financed by the federal government (i.e., the applicable federal medical assistance percentage would be 100%) for the period 2013-2014, decreasing to 90% beginning in 2015. These groups would also include individuals covered under Medicaid waivers and those receiving coverage paid for with state only funds.

The Medicaid statutory language that deems certain newborns to be eligible for Medicaid for up to one year would be extended to include children born in the U.S up to the first 60 days of life who do not have acceptable coverage upon birth. Benefits provided to such children would also be fully financed by the federal government (i.e., the applicable federal medical assistance percentage would be 100%) for the period 2013-2014, decreasing to 90% beginning in 2015.

States would not be permitted to enroll non-traditional Medicaid eligibles in a managed care entity unless the state demonstrates that the entity has the capacity to meet the health, mental health, and substance abuse needs of such individuals.

Medicaid Coordination with Health Insurance Exchange

H.R. 3200 includes a provision that would require state Medicaid agencies to enter into a Medicaid memorandum of understanding (MOU) with the Health Choices Commissioner, acting in consultation with the Secretary, to coordinate implementation of the provisions on private health insurance, the Health Insurance Exchange, and health insurance premium credits with the Medicaid state plan to ensure the enrollment of Medicaid eligible individuals in acceptable coverage. Pursuant to this MOU, states would be required to accept without further determination the enrollment of traditional and non-traditional Medicaid eligible individuals (defined above) who are determined eligible by the Exchange. The state may conduct redeterminations of eligibility for these individuals consistent with the periodicity outlined in the MOU.

States would be required to provide Medicaid coverage during a period of presumptive eligibility. Once such an individual has made an application for Medicaid, states must promptly make a determination of eligibility (and for subsequent redeterminations) in the same manner as if the individual had applied directly to the state for Medicaid coverage, and use the income-related information used by the Commissioner and provided to the state under the MOU for making presumptive eligibility determinations to the maximum extent feasible.

If the Commissioner determines that a state Medicaid agency has the capacity to make determinations of eligibility for health insurance affordablity credits, then the MOU would provide for the following: (1) the state Medicaid agency must conduct such determinations for any Exchange-eligible individual who requests such a determination; (2) in the case that a state Medicaid agency determines that an Exchange-eligible individual is not eligible for affordability credits, the agency must forward the information on the basis of which such determination was made to the Commissioner; and (3) the Commissioner must reimburse the state Medicaid agency for the costs of conducting such determinations.

In the case of a child born in the United States who at the time of birth is not otherwise covered under acceptable coverage, the child would be deemed to be a non-traditional Medicaid eligible and enrolled in Medicaid. For such children, the state would provide for a Medicaid eligibility determination not later than the date the child otherwise is covered under acceptable coverage (or, if earlier, the end of the month in which the 60-day period, beginning on the date of birth, ends). For such children who still do not have acceptable coverage at the end of the above defined period, the child would be deemed to be a traditional Medicaid eligible individual until such time as the child obtains acceptable coverage or the state otherwise determines the child to be eligible for the state Medicaid plan.

Medicaid and CHIP Maintenance of Current Eligibility

As a condition of continued availability of federal Medicaid matching funds, states would not be permitted to adopt eligibility standards, methodologies, or procedures in their Medicaid or CHIP programs (including waivers)[6] that would be more restrictive than those in effect as of June 16, 2009. States would not be permitted to apply any asset or resource test in determining (or re-determining) eligibility for individuals in specified Medicaid eligibility groups (e.g., individuals who would qualify for the Supplemental Security Income for the Aged, Blind and Disabled program, the former AFDC program, and the Foster Care or Adoption Assistance (Title IV-Part E) program; certain first-time pregnant women who would be eligible for Temporary Assistance to Needy Families (TANF) if the child was born; pregnant women and children under age six with family income below 133⅓% of the federal poverty level (FPL); and families who meet the requirements of the former AFDC programs in effect in their states on July 16, 1996). Medicaid benchmark or benchmark equivalent coverage[7] must meet the minimum benefits and cost-sharing standards of a basic plan offered through the Health Insurance Exchange (the Exchange).

With regard to the CHIP program, once the Exchange is operational[8] the CHIP maintenance of effort (MOE) requirements would terminate and CHIP eligibles would receive coverage through the Exchange. The CHIP MOE provision would not prevent a state from imposing limitations (e.g., limiting acceptance of applications or imposing a waiting list) in order to limit expenditures under dental-only separate CHIP programs (per Section 2105 of the Social Security Act) for that fiscal year.

Finally, the Secretary may waive the MOE provisions under certain circumstances in situations where states covered premium and cost-sharing. The Secretary would be authorized to waive

[6] The Secretary of the Department of Health and Human Services would be required to extend authority and federal financial participation for Section 1115 demonstration waivers for such period as may be required for a state to meet the maintenance of effort requirement.

[7] For more information on Medicaid Benchmark or benchmark-equivalent coverage, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

[8] In 2013 or, if later, the date on which the Health Choices Commissioner determines that the Exchange has the capacity to support CHIP enrollees and the Secretary determines that procedures are in place to ensure a timely transition without interruption in coverage.

states' MOE requirements when states had Medicaid or CHIP Sec. 1115 demonstration waivers that extended coverage to childless individuals solely for subsidies for health insurance premium or cost-sharing. The 1115 waivers would need to have been in effect as of June 16, 2009. Under this provision, effective for coverage in 2013, the Secretary may permit states to amend their 1115 waivers to apply more restrictive eligibility standards, methodologies, or procedures for the individuals covered by these waivers without regard to the Medicaid and CHIP maintenance of eligibility requirements specified above.

Finally, in case of a state with a Medicaid or CHIP waiver under Section 1115 in effect on June 16, 2009, that permits childless individuals to be eligible solely to receive a premium or cost-sharing subsidy for individual health insurance coverage, effective for coverage provided in 2013, the Secretary may permit the state to amend such waiver to apply more restrictive eligibility standards, methodologies, or procedures with respect to such individuals under the waiver without regard to the Medicaid and CHIP maintenance of eligibility requirements specified above.

Optional Eligibility Expansions

H.R. 3200 would add two new optional categorically needy eligibility groups to Medicaid. One new group would be comprised of (1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under a Medicaid or CHIP state plan, and (2) certain individuals eligible for existing Section 1115 waivers that provide family planning services and supplies. Benefits for such individuals would be limited to family planning services and supplies and also would include related medical diagnosis and treatment services. The provision also would allow states to make a "presumptive eligibility" determination for individuals eligible for such services through the new optional eligibility group. That is, states may enroll such individuals for a limited period of time before full Medicaid applications are filed and processed, based on a preliminary determination by Medicaid providers of likely Medicaid eligibility. (Under current law, such presumptive eligibility determinations can be made for children, pregnant women, and certain women with breast or cervical cancer.) During periods of presumptive eligibility, family planning services and supplies would be covered, and states would have the option to also cover related medical diagnosis and treatment services. In addition, states would not be allowed to provide Medicaid coverage through benchmark or benchmark-equivalent plans, which are permissible alternatives to traditional Medicaid benefits for some Medicaid beneficiaries under current law, unless such coverage includes family planning services and supplies.

The second new optional eligibility group would be comprised of individuals who have HIV infection with income and resources that do not exceed the income and resource levels for that state's SSI-related Medicaid eligibility group. The federal government's share of expenditures for this new eligibility group would be based on the enhanced federal medical assistance percentage (FMAP) created under H.R. 3200 that provides coverage for traditional and non-traditional Medicaid beneficiaries up to 133⅓% of FPL. The medical expenditures associated with this group in the territories would be matched without regard to the existing Medicaid spending caps.

Provisions of H.R. 3200 that Modify Existing Eligibility Groups

Extension of Transitional Medical Assistance (TMA) Coverage

States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation is called

transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or employment hours.

However, in 1988, Congress expanded work-related TMA (under Section 1925 of the Medicaid statute), requiring states to provide at least six, with the option to provide up to 12, months of coverage. Since 2001, these work-related TMA requirements have been funded by a series of short-term extensions. In the latest Congressional action, the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) extends work-related TMA through December 31, 2010. H.R. 3200 would further extend work-related TMA under Section 1925 through December 31, 2012.

Extension of Qualified Individual (QI) Program

Certain low-income individuals who are aged or have disabilities, as defined under the Supplemental Security Income (SSI) program, and who are eligible for Medicare are also eligible to have their Medicare Part B premiums paid for by Medicaid under the Medicare Savings Program (MSP). Eligible groups include Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs). QMBs have incomes no greater than 100% of the federal poverty level (FPL) and assets no greater than $4,000 for an individual and $6,000 for a couple. SLMBs meet QMB criteria, except that their incomes are greater than 100% of FPL but do not exceed 120% FPL. QIs meet the QMB criteria, except that their income is between 120% and 135% of poverty and they are not otherwise eligible for Medicaid. The federal government currently pays 100% of the costs of QIs up to state allocation amounts. The QI program is currently slated to terminate December 2010. H.R. 3200 as amended would extend the QI group through December 2012. The federal government would continue to pay 100% of the cost of this group. State allocation limits would no longer apply.

Outreach and Enrollment Facilitation

Expanded Outstationing

Under current law, a Medicaid state plan must provide for the receipt and initial processing of applications for medical assistance for low-income pregnant women, infants, and children under age 19 at outstation locations other than TANF offices, such as disproportionate share hospitals and Federally-qualified health centers (FQHCs). State eligibility workers assigned to outstation locations perform initial processing of Medicaid applications including taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews. States must also use applications which are other than those used for aid under TANF.

H.R. 3200 would require states to provide for receipt and initial processing of Medicaid applications at specified outstation locations for *all* Medicaid applicants, and would require state Medicaid programs to allow individuals applying for affordability credits (under subtitle C of title II of Division A) to apply for Medicaid coverage at Disproportionate Share Hospitals (DSH) hospitals, FQHCs, and locations apart from welfare offices.

Preserving Medicaid Coverage for Youth Upon Release from Public Institutions

In general, no federal matching funds are available for medical services delivered to inmates of public institutions. Such public institutions are the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Federal rules do not require states to terminate Medicaid eligibility for inmates (individuals residing in a public institution), but research indicates that most states do so.

For certain youth, H.R. 3200 would require that states not terminate Medicaid eligibility during periods of incarceration in a public institution. States would also be required to establish a process that ensures that no claims for federal matching funds be made for services delivered to youth while in a public institution and that such youth receive Medicaid services for which federal matching funds would be available. States must ensure that enrollment in Medicaid for such youth be completed before their release date. This provision would be applicable to an individual who (1) is 18 years of age or younger, (2) was enrolled in Medicaid under the state plan immediately before becoming an inmate of a public institution, (3) is 18 years of age or younger upon release from such institution, and (4) is eligible for Medicaid under the state plan at the time of his/her release.

12-Month Continuous Coverage Under Certain CHIP Programs

Under CHIP, states may enroll targeted low-income children in a CHIP-financed expansion of Medicaid, create a new separate state CHIP program, or devise a combination of both approaches. States are required to re-determine CHIP eligibility at least every 12 months with respect to circumstances that may change and affect eligibility. Continuous eligibility allows a child to remain enrolled for a set period of time regardless of whether the child's circumstances change (e.g., the family's income rises above the eligibility threshold), thus making it easier for a child to stay enrolled. Not all states offer it, but among those that do, the period of continuous eligibility ranges from six months to 12 months. H.R. 3200 as amended would require separate CHIP programs that cover children in families with annual income less than 200% of the federal poverty level to provide for 12 months of continuous coverage.

Preventing the Application under CHIP of Coverage Waiting Periods

Federal CHIP statute allows states to use a number of factors in determining eligibility for beneficiaries. However, states are not permitted to (1) extend coverage to children in families with higher family income without covering children with lower family income; (2) deny eligibility based on a preexisting medical condition; (3) apply a waiting period to targeted low-income pregnant woman who qualify for pregnancy-related assistance, or (4) apply a waiting period in the case of a child who is eligible for dental-only supplemental coverage.

H.R. 3200 would preclude states from applying a waiting period to children applying for child health assistance who are (1) under two years of age; (2) who lost health insurance coverage under a group health plan or health insurance coverage offered through an employer due to (a) a loss of a job, (b) a reduction in work hours, (c) the elimination of an individual's retiree health benefits, or (d) the termination of an individual's health insurance coverage offered through an employer; or (3) the family of the child demonstrates that the cost of health insurance coverage (including the cost of premiums, co-payments, deductibles, and other cost sharing) exceeds 10% of the family income.

Outreach and Enrollment of Medicaid and CHIP Eligible Individuals.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) included provisions to facilitate access and enrollment in Medicaid and CHIP. Among the provisions related to outreach and enrollment, CHIPRA authorizes $100 million in outreach and enrollment grants above and beyond the regular CHIP allotments for fiscal years 2009 through 2013. Ten percent of the outreach and enrollment grants will be directed to a national enrollment campaign, and 10% will be targeted to outreach for Native American children. The remaining 80% will be distributed among state and local governments and to community-based organizations for purposes of conducting outreach campaigns with a particular focus on rural areas and underserved populations. Grant funds will also be targeted at proposals that address cultural and linguistic barriers to enrollment. Also as a part of the outreach-related provisions, CHIPRA requires state plans to describe the procedures used to reduce the administrative barriers to the enrollment of children and pregnant women in Medicaid and CHIP, and to ensure that such procedures are revised as often as the state determines is appropriate to reduce newly identified barriers to enrollment.

H.R. 3200 would require the Secretary to issue guidance regarding standards and best practices (e.g., outstationing of eligibility workers, express lane eligibility, presumptive eligibility, continuous eligibility, and automatic renewal) to facilitate outreach and enrollment of eligible individuals in Medicaid and/or CHIP. Such guidance would be required to be issued not later than 12 months after date of enactment of this Act and must target vulnerable populations (e.g., unaccompanied homeless youth, victims of abuse or trauma, persons with mental health or substance related disorders, and individuals with HIV/AIDS). In implementing the requirements of this provision, the Secretary would be permitted to use such authorities as are available under law and may work with such entities as the Secretary deems appropriate to facilitate effective implementation of such programs. Not later than two years after the enactment of this Act and annually thereafter, the Secretary would be required to review and report to Congress on progress in implementing targeted outreach, application and enrollment assistance, and administrative simplification methods for such vulnerable and underserved populations.

Medicaid Coverage for Citizens of Freely Associated States

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193) limited access of noncitizens (aliens) to certain federal benefits including eligibility for non-emergency Medicaid, food stamps, Supplemental Security Income (SSI), and TANF to only those categories of aliens considered "qualified aliens" (e.g., legal permanent residents, asylees, and refugees). Citizens of the Freely Associated States (i.e., citizens of the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau) are not considered qualified aliens under PRWORA. Prior to PRWORA, citizens of the Freely Associated States were not barred from Medicaid. In addition, under current law with some exceptions, qualified aliens arriving in the United States after August 22, 1996, are barred from full-Medicaid coverage for the first five years after entry. Coverage of such persons after the five-year bar is permitted at state option if such individuals meet other eligibility requirements.

H.R. 3200 would make citizens of the Freely Associated States eligible for full Medicaid (without regard to the five-year bar) if they are (1) lawfully residing in the United States (including territories and possessions of the United States) in accordance with the Compacts of Free Association between the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau, and (2) are otherwise eligible for such coverage.

State Option to Disregard Certain Income in Providing Continued Medicaid Coverage for Certain Individuals with Extremely High Prescription Costs

Outpatient prescription drugs are an optional Medicaid benefit, but all states cover prescription drugs for most beneficiary groups. Under Medicaid law, states must cover certain categories of low-income individuals. These "categorically eligible" individuals include low-income pregnant women, children, families with dependent children, the elderly, and certain people with disabilities. States have the option to extend coverage to other individuals that meet these categorical requirements, but have higher income levels.

For most beneficiaries and services, state Medicaid programs are allowed to establish "nominal" service-related cost-sharing requirements. Nominal amounts are defined in regulations and are generally between $0.50 and $3 (adjusted annually for medical inflation), depending on the cost of the service provided. As an alternative to these traditional, nominal cost-sharing rules, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) provided a state option for beneficiary cost-sharing under Medicaid. For individuals in families with income below 100% FPL, service-related cost-sharing cannot exceed nominal amounts. For individuals in families with income between 100 and 150% FPL, service-related cost-sharing cannot exceed 10% of the cost of the item or service. For individuals in families with income above 150% FPL, service-related cost-sharing cannot exceed 20% of the cost of the item or service. For all individuals, the total aggregate amount of all cost-sharing cannot exceed 5% of monthly or quarterly family income (as determined by the state). Certain groups and services are exempt from the application of the nominal cost-sharing rules and the DRA cost-sharing rules.

Under H.R. 3200, states would have the option to disregard certain income when redetermining eligibility for certain individuals with extremely high prescription drug costs. To be eligible for this special disregard, individuals would have to have been otherwise determined eligible for Medicaid without the application of this special disregard.

An individual with extremely high prescription drug costs for a 12-month period would be someone (1) who has health insurance coverage, including prescription drug coverage, that has a maximum lifetime limit of at least $1 million; (2) who has exhausted all available prescription drug coverage as of the beginning of such period; (3) who incurs (or is reasonably expected to incur) annual prescription drug costs for orphan drugs (for rare diseases or conditions as designated under Section 526 of the Federal Food, Drug and Cosmetic Act) in excess of $200,000 (adjusted for medical inflation after 2010); and (4) whose annual family income at the beginning of the period does not exceed 75% of the amount incurred for such orphan drugs.

States would have the option to apply family income disregards in determining such an individual's Medicaid eligibility at any level so long as the income disregard does not exceed $200,000 in 2009 or 2010, with this ceiling adjusted for medical inflation in subsequent years. For otherwise eligible individuals with income exceeding this ceiling, states may disregard income equal to the cost of the orphan drugs used by the applicant. Expenditures for cosmetic drugs would not be counted. States would be required to at least apply Medicaid's nominal cost-sharing rules to these beneficiaries, and would have the option to apply additional cost-sharing up to a maximum amount specified by the Secretary (and adjusted on an annual basis), consistent with the DRA cost sharing rules. Finally, states would be required to consider an individual's re-application for Medicaid under this provision within 30 days of the date the application was filed.

Prohibitions on Federal Medicaid and CHIP Payment for Undocumented Aliens

Under current law, unauthorized aliens (i.e., illegal aliens, foreign nationals who are not lawfully present in the United States) are ineligible for Medicaid and CHIP. Such individuals who meet the categorical and residency eligibility requirements for Medicaid, but are ineligible due to immigration status, are only eligible for Medicaid coverage for emergency conditions (i.e., emergency Medicaid), which includes costs associated with labor and delivery for pregnant women. H.R. 3200 would specify that nothing would change the current prohibitions against federal Medicaid and CHIP payments on behalf of individuals who are not lawfully present in the United States. Since the provision reiterates current law, certain unauthorized aliens would still be eligible for emergency Medicaid services only, and providers could still obtain Medicaid reimbursement for such care.

Benefits

Medicaid benefits are identified in federal statute and regulations and include a wide range of medical care and services. Some benefits are specific items, such as eyeglasses and prosthetic devices. Other benefits are defined in terms of specific types of providers (e.g., physicians, hospitals). Still other benefits define specific types of services (e.g., family planning services and supplies, pregnancy-related services) that may be delivered by any qualified medical provider that participates in Medicaid. Finally, additional benefits include premium payments for coverage provided through managed care arrangements and Medicare premium and cost-sharing support for persons dually eligible for both Medicare and Medicaid.

Medicaid's basic benefit rules require all states to provide certain "mandatory" services (e.g., inpatient hospital care, physician services, lab/x-ray services). The statute lists additional services that are considered optional (e.g., other licensed practitioners, rehabilitative services, nursing facility services for individuals under age 21) - that is, federal matching payments are available for optional services if states choose to include them in their Medicaid plans. States define the specific features of each mandatory and optional service to be provided under that plan within broad federal guidelines.

H.R. 3200 would make a number of changes to benefits under the Medicaid program. For example, this bill would add a new mandatory benefit for coverage of certain preventive services. The bill would also add some optional Medicaid benefits (e.g., nurse home visitation services) and clarify the availability of certain existing optional services under current law (e.g., therapeutic foster care services, adult day health care). H.R. 3200 also makes coverage of services provided by podiatrists and optometrists mandatory, rather than optional as under current law. These and other proposed benefit changes are described below.

New Mandatory Medicaid Benefits Added Under H.R. 3200

Required Coverage of Preventive Services

Medicaid statute lists types of services covered under Medicaid, some of which are mandatory benefits, and others are optional. For beneficiaries under 21 years of age, states must cover a package of preventive services under the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT). Current law does not explicitly require state plans to cover

preventive services for adults, although coverage may be required if a service meets another applicable requirement, such as physicians' services.

H.R. 3200 would require Medicaid state plans to cover, for all beneficiaries, preventive services that the Secretary determines are (1) services recommended by the Task Force on Clinical Preventive Services (established by this bill), or vaccines recommended by the Centers for Disease Control and Prevention (CDC), and (2) appropriate for Medicaid beneficiaries. This section would also amend Section 1928 of the Social Security Act (SSA) to clarify that vaccines covered under the Vaccines for Children (VFC) authority are those recommended by the CDC Director, rather than an advisory committee to the Director, and would also prohibit cost-sharing for the preventive services identified in this section, including cost-sharing otherwise permitted under traditional Medicaid and the optional alternative cost-sharing structure defined under DRA.

Mandatory Coverage of Podiatrists and Optometrists

Some standard Medicaid benefits are mandatory for most Medicaid groups (e.g., inpatient hospital services, physician services, family planning services and supplies, federally qualified health center services, nursing facility services for persons age 21 or older). Under Medicaid, physician services are those furnished by a physician as defined in the Medicare statute, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere. Other benefits are optional. Examples of optional benefits for most Medicaid groups that are offered by many states include prescribed drugs (covered by all states), other licensed practitioners (e.g., podiatrists, optometrists, chiropractors, psychologists), and nursing facility services for individuals under age 21 years.

H.R. 3200 would modify the definition of mandatory "physician services" under Medicaid to also include a doctor of podiatric medicine as defined in the Medicare statute, effective as of January 1, 2010. Similarly, the bill would make services provided by optometrists as defined in the Medicare statute a new mandatory benefit under Medicaid. This latter provision would take effect 90 days after enactment of this bill.

Inclusion of Public Health Clinics Under the Vaccines for Children Program

Section 1928 of the SSA authorizes the VFC program, under which Medicaid assumes the costs for providing certain low-income children with recommended vaccinations. Medicaid law further defines children who are eligible for vaccines as those who are eligible for Medicaid; who are uninsured; and who receive vaccines purchased through the program and administered at a FQHC or rural health clinic, and do not have health insurance coverage for vaccines, or who are Indians.

H.R. 3200 would add public health clinics to the list of providers that may administer vaccines to eligible children under the VFC program.

Continuing Requirement of Medicaid Coverage of Non-Emergency Transportation to Medically Necessary Services

Federal regulations (42 CFR 431.35) require state Medicaid plans to assure necessary transportation for recipients to and from providers, and describe the methods that the agency will use to meet those requirements. In late 2007, the Bush Administration issued a final rule (effective February 26, 2008) that would have eliminated Medicaid reimbursement for school-based administrative costs and costs of transportation to and from school. That rule modified the existing federal regulation on assurance of transportation, adding that for the purposes of this

assurance, necessary transportation did not include transportation of school-age children between home and school.

Subsequent to the publication of this final rule, Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) imposed a moratorium on further action until June 30, 2008. This moratorium prevented the Centers for Medicare and Medicaid Services (CMS) from imposing restrictions contained in this rule that were more stringent than those applicable as of July 1, 2007. This moratorium was extended twice, first until April 1, 2009 (via Supplemental Appropriations Act, 2008, P.L. 110-252) and then until July 1, 2009 (via American Recovery and Reinvestment Act of 2009, P.L. 111-5). On June 29, 2009, the Obama Administration announced that it would rescind the final rule on school-based administration and transportation.[9]

H.R. 3200 would add non-emergency transportation to medically necessary services, consistent with 42 CFR 431.53 as in effect as of June 1, 2008 (when the Bush Administration final rule was not in effect), to the list of mandatory Medicaid benefits identified in federal statute that are available to Medicaid beneficiaries eligible under the state Medicaid plan.

New Optional Medicaid Benefits Added Under H.R. 3200

Tobacco Cessation

Federal Medicaid law permits states to exclude coverage of 11 drug classes, including barbiturates, benzodiazepines, and smoking cessation products. States still may cover these and other excluded drugs. When Medicare Part D was implemented in January 2006, Medicare began covering prescription drugs for dually eligible individuals.[10] Barbiturates and benzodiazepines were excluded from the Medicare Part D formulary as well as Medicaid, although certain other Medicaid-excluded drugs were included on the Part D formulary. However, under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), Medicare prescription drug plans and Medicare Advantage plans were required to include barbiturates and benzodiazepines in their formularies for prescriptions dispensed on or after January 1, 2013.[11] Under current law, Medicaid programs may cover tobacco cessation counseling services for pregnant women as an optional benefit, but if tobacco cessation products are dispensed as part of that counseling, states would not receive FFP for the drugs.

Under H.R. 3200 , as of January 1, 2010, tobacco cessation products would be removed from Medicaid's excluded drug list.

Optional Coverage of Nurse Home Visitation Services

States can seek federal reimbursement (at the 50% matching rate typically available for administrative activities) for home visitation services under Medicaid administrative case management. These administrative activities are defined as activities necessary for the proper and efficient operation of the state Medicaid plan (e.g., outreach, eligibility determinations, utilization review, and prior authorization).

Under EPSDT benefits, a mandatory service for individuals under age 21, states can seek Medicaid reimbursement for care coordination and/or case management provided through home

[9] For more information, see 74 *Federal Register* 31183.

[10] Dual eligibles refers to individuals who are eligible for both Medicare and Medicaid.

[11] Barbiturates also will be required to be on the Medicare formularies for the indications of epilepsy, cancer, or chronic mental health disorder.

visitation services. Such EPSDT-related home visitation may be covered as an administrative cost (reimbursed at the 50% administrative matching rate), or as medical assistance (reimbursed at the state's regular FMAP rate) in the case of medically necessary case management.

H.R. 3200 would give states a new option to cover certain nurse home-visitation services for first-time pregnant women or children under age two.

Translation or Interpretation Services

Federal and state governments share in the cost of Medicaid benefits based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa). The federal matching rate for administrative expenditures is the same for all states and is generally 50%, but certain administrative functions have a higher federal matching rate. States have the option of covering language translation or interpretation services as a benefit, so Medicaid programs could receive federal financial participation for these services. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) provided a 75% matching rate for language translation or interpretation services in connection with the enrollment and retention of, and use of services under Medicaid by children of families for whom English is not the primary language.

Under H.R. 3200 , beginning January 1, 2010, states would receive the 75% matching rate for translation and interpretation services for other Medicaid beneficiaries, in addition to children of families whose primary language is not English.

Optional Coverage for Free Standing Birth Center Services

While there is statutory authority under Medicaid to pay for services rendered by nurse midwives, there is no statutory authority to provide for direct payments to freestanding birthing centers for facility services. H.R. 3200 would add an optional benefit for freestanding birth center services and other ambulatory services offered by a freestanding birth center that are otherwise covered under the state Medicaid plan. The term "freestanding birth center services" would be defined as services furnished to an individual at a freestanding birth center, including by a licensed birth attendant. The term "freestanding birth center" would be defined as a health facility that is not a hospital and where childbirth is planned to occur away from the pregnant woman's residence. The term "licensed birth attendant" would be defined as an individual who is licensed or registered by the state to provide health care at childbirth and who provides such care within the scope of practice and which the individual is legally authorized to perform under state law (or state regulatory mechanism provided by state law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. This provision would not change state law requirements applicable to licensed birth attendants.

Optional Therapeutic Foster Care (TFC) Services

In general, TFC places troubled youth (those having serious emotional and behavioral issues) with specially trained families in a structured environment to promote positive social behavior and minimize disruptive and aggressive behavior. TFC is not specifically addressed in Medicaid law, although it has been considered rehabilitative services. Under Medicaid, states have the option to cover rehabilitation services, including medical or remedial services to reduce physical or mental disability, and for restoration of the best possible functional level. There has been debate about whether TFC should be considered a medical treatment, and whether it should be covered and paid for as a foster care benefit or as a Medicaid benefit. In August of 2007, CMS issued a proposed rule for Medicaid rehabilitative services. That rule, among others, was subject

to a moratorium on further administrative action until April 1, 2009. ARRA included a Sense of the Senate provision that CMS should not promulgate a final rule for rehabilitative services.

H.R. 3200 would clarify that states have the option under Medicaid to cover TFC for Medicaid eligible children in out-of-home placements. TFC would be defined as a foster care program that provides certain services to parents (e.g., specialized training and consultation on management of troubled youth placed in their care) and children (e.g., structured activities to promote age-appropriate behaviors, crisis intervention, medication monitoring, and case management services).

Adult Day Health Care Services

Like TFC, adult day health care services are not specifically addressed in current Medicaid law, although these services are often classified as rehabilitative services. There has also been disagreement about whether adult day health care services should be considered medical treatment and whether individuals using these services are receiving rehabilitative services or care that is more in the nature of custodial, habilitative services. Also, as noted above with respect to TFC, CMS issued a proposed rehabilitative services rule in August of 2007. That rule sought to clarify the distinction between rehabilitative services that focus on restoration of individuals' functional levels and habilitative services designed to help people acquire new functional abilities.

Under a 1989 law, CMS was forbidden from taking adverse action against states that were approved to cover habilitative services until regulations were issued specifying the types of day habilitation services that states could cover under Medicaid. The proposed rehabilitation services rule would also have withdrawn prior approval of habilitative services in states grandfathered under that same 1989 law. As noted above, Congress imposed a moratorium on further administrative action on the rehabilitative services rule, along with other administrative rules, until April 1, 2009. Subsequently, ARRA included a Sense of the Congress provision that CMS should not promulgate a final rule for rehabilitative services.

H.R. 3200 would prohibit the Secretary from denying federal reimbursement for adult day health care services, day activity and health services, or adult medical day care services, as defined under a state Medicaid plan approved before 1995. The Secretary would also be prohibited from withdrawing federal approval (by regulation or otherwise) for the provision of such services under such a state's Medicaid plan. This provision would apply to services provided on or after October 1, 2008.

Financing

Medicaid financing is shared by the federal government and the states. The federal share for most Medicaid expenses for benefits is determined by the federal medical assistance percentage (FMAP). FMAP is based on a formula that provides higher reimbursement to states with lower per capita income relative to the national average (and vice versa). FMAPs have a statutory minimum of 50% and maximum of 83%, although some Medicaid services receive a higher federal match rate. FY2009 FMAPs ranged from a high of 75.8% in Mississippi to a low of 50.0% in 13 other states. In February of this year, with passage of ARRA, states received temporary enhanced FMAP rates for nine quarters beginning with the first quarter of FY2009 and running through the first quarter of FY2011.

State expenditures to administer their Medicaid programs are matched by federal funding at the 50% matching funding rate. Federal matching rates for administrative expenditures are the same

for all states, although some activities are matched at higher rates. Within broad federal guidelines, states generally control Medicaid spending levels by tailoring eligibility, covered services, cost-sharing and premiums paid by beneficiaries, provider reimbursement rates, and other program components to achieve their budget and policy goals. To receive payment for the federal share of Medicaid expenditures, states submit quarterly expenditure reports to the Centers for Medicare and Medicaid Services (CMS).

The Medicaid financing provisions in H.R. 3200 generally can be considered technical changes or refinements that would reduce federal and state health care expenditures. The proposed changes would affect Medicaid purchases of prescription drugs, disproportionate share hospital (DSH) payments, and graduate medical education (GME) payments. Some of the Medicaid financing provisions in H.R. 3200 , discussed in this section, appear in two Subtitles. Division B, Title VII—Medicaid and CHIP, Subtitle A—Medicaid and Health Reform contains a DSH financing provision, and Subtitle E—Financing, contains provisions on prescription drugs and GME.

Payments to States

Disproportionate Share Hospital Payments

Medicaid statute requires that states make disproportionate share (DSH) adjustments to the payment rates of hospitals treating large numbers of uninsured individuals and Medicaid beneficiaries. Federal statute specifies a formula for determining DSH allotments for each state. States must define, in their state Medicaid plan, hospitals qualifying as DSH hospitals and DSH payment formulas, taking into account certain federal criteria.[12] For FY1998-FY2002, state-by-state DSH allotments were specified in federal statute. A number of changes to these allotments occurred after that time.

H.R. 3200 would require the Secretary to provide a report to Congress (due January 1, 2016), on the extent to which, based on the impact of provisions included in the bill aimed at reducing the number of uninsured, there is a continued role for Medicaid DSH payments. The bill also would require the Secretary to reduce Medicaid DSH payments to states by a total of $10.0 billion (i.e., $1.5 billion in FY2017, $2.5 billion in FY2018, and $6.0 billion in FY2019) based on a methodology that imposes the largest percentage reductions on states with lower uninsured rates or that do not target their DSH payments to hospitals with high volumes of Medicaid inpatients or high levels of uncompensated care.

Graduate Medical Education (GME)

Most states make Medicaid payments to help cover the costs of training new doctors in teaching hospitals and other teaching programs. There is no formal federal reporting mechanism to document Medicaid GME payments made by states. In 2005, total state and federal Medicaid payments for GME were estimated to be nearly $3.2 billion.[13] On average, Medicaid GME payments were estimated to represent 7% of total Medicaid inpatient hospital expenditures.[14] In May 2007, CMS issued a proposed rule that would have eliminated federal reimbursement for

[12] For more information on Medicaid DSH, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*.

[13] For comparison, Medicare spent about $8.4 billion on GME in 2007. State support for GME may also include appropriations to state-operated medical schools or residency programs.

[14] For more information, see CRS Report RS22842, *Medicaid and Graduate Medical Education*, by Elicia J. Herz and Sibyl Tilson.

GME under Medicaid.[15] Subsequent federal laws have placed a moratorium on further action on this rule. Most recently, ARRA included a Sense of the Senate provision that the Secretary should not promulgate a final GME payment rule. In its May 11, 2009, unified agenda for forthcoming regulatory action, HHS indicated that final action is "to be determined" on the proposed Medicaid GME rule.

H.R. 3200 would explicitly authorize GME payments under Medicaid, whether the GME occurred in or outside of a hospital. To increase transparency and enable GME funds to be monitored, states would be required to provide timely information to the Secretary on annual GME payments. States would be required to report total GME payments and how these payments were used including (1) the institutions and programs eligible for receiving the funding, (2) the manner in which such payments are calculated, (3) the types and fields of education being supported, (4) the workforce or other goals to which the funding is being applied, (5) state progress in meeting workforce or other state GME funding goals, and (6) other information the Secretary determines will assist states in supporting other types and fields of education and workforce goals. In addition, H.R. 3200 also would require that the information reported to the Secretary is provided to an Advisory Committee on Health Workforce Evaluation and Assessment, and the Secretary and this advisory committee would independently review the state information. The Secretary also would be required to issue rules before December 31, 2011 on programs goals for Medicaid GME payments, and requirements for use of GME funds. Finally, the bill would add a state option to make hospital GME payments under Medicaid, consistent with the other provisions of this section of the bill. These provisions would be effective upon enactment of H.R. 3200, and nothing in this section of the bill would affect payments made before such date under a state Medicaid plan for graduate medical education.

Extension of the Delay in the Elimination of Managed Care Organization Provider Tax

States' ability to use provider-specific taxes to fund Medicaid is limited. If a state establishes provider-specific taxes to fund the state share of program costs, federal matching dollars will not be available unless the tax program meets three rules: (1) the taxes collected cannot exceed 25% of the state (non-federal) share of Medicaid expenditures, (2) the state cannot provide a guarantee to the providers that the taxes will be returned to them, and (3) the tax must be broad-based (i.e., the tax is uniformly applied to all providers within the provider class). Per DRA, the Medicaid managed care organization (MCO) provider class includes all MCOs. That is, to qualify for federal matching dollars, a state's provider tax must apply to both Medicaid and non-Medicaid MCOs. This provision was effective upon enactment of DRA (as of February 8, 2006), except in states with taxes based on the Medicaid provider tax class defined in prior law that was in place as of December 8, 2005. In that prior law, MCOs were classified as a separate class of providers for the purposes of determining if a tax was broad-based, and was limited to only Medicaid providers (not all MCOs including non-Medicaid MCOs). In those states, this exception to the DRA MCO provider tax rule was to be effective on October 1, 2009.

H.R. 3200 would extend the effective date from October 1, 2009 to October 1, 2010 for those states with provider taxes based on the prior Medicaid provider tax classification (described above) that was in place as of December 8, 2005. This change would be effective as if included in DRA.

[15] For more information on the status of the GME and other regulations issued by CMS, see CRS Report RL34764, *Medicaid Regulatory Issues*, by Elicia J. Herz and Vanessa K. Burrows.

Technical Corrections: Medicaid Medical Assistance Payments

Medicaid medical assistance refers to payment for part or all of the cost of care and services covered under a state's Medicaid program on behalf of individuals eligible for benefits. H.R. 3200 would make a technical correction to the definition of Medicaid medical assistance to include payment for part or all of the cost of care and services, or the care and services themselves, or both covered under a state's Medicaid program on behalf of individuals eligible for benefits.

Payments to Providers

Reimbursement Rates for Primary Care Services

Under current law, state Medicaid plans must provide methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care is available to the general population in the geographic area. Additional requirements regarding payment rates under Medicaid apply to inpatient hospital and long-term care facility services.

Under H.R. 3200, states would be required to set Medicaid payments for primary care services (as defined under Medicare) at 80% of the Medicare physician fee schedule for services rendered by physicians or other health care professionals in 2010, 90% of such rates in 2011, and 100% of such rates in 2012 forward. The provision also would require that, in the case of primary care services, these payment rates would apply, regardless of the manner in which such payments are made, including in the form of capitation or partial capitation (e.g., payments made on a "per member per month" basis, rather than for each specific unit of service delivered). For services furnished after January 1, 2010, the federal government would fully finance the portion of such payments by which the new minimum payment rates specified above exceed payment rates in effect in June 2009. The regular FMAP rates would apply to the portion of payments for primary care services that exceed the rate established for such services (as a percentage of the Medicare physician fee schedule as described above).

Assuring Adequate Payment Levels for Services

The state Medicaid plan must provide methods and procedures (1) relating to the utilization of and the payment for care and services available under the plan as necessary to safeguard against unnecessary utilization, and (2) to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

H.R. 3200 would require that state Medicaid plans be considered out of compliance with these statutory requirements unless certain conditions are met. Beginning in 2011, states would be required to submit annually to the Secretary a state Medicaid plan amendment (SPA) that details payment rates for that year and specified additional data (i.e., how Medicaid managed care payments take into account provider payment rates) that would assist in the evaluation of states' compliance with this requirement. If the Secretary disapproves the state's SPA, states would be required to submit a revised amendment that complies with these requirements. This provision would take effect on the date of enactment of this bill.

Prescription Drugs

Outpatient prescription drugs are an optional Medicaid benefit, but all states cover prescription drugs for most beneficiary groups. States purchase prescription drugs from drug manufacturers on behalf of Medicaid beneficiaries and receive matching federal payments for a portion of these purchases, just as they do for other medical services. Medicaid law requires drug manufacturers to ensure that Medicaid receives their "best price." The best price provisions require prescription drug manufacturers, who wish to sell any products to Medicaid beneficiaries, to enter into rebate agreements with the Secretary on behalf of states. Under these agreements, drug manufacturers must provide state Medicaid programs with rebates for the drugs purchased for Medicaid beneficiaries.[16] In exchange for entering into rebate agreements, state Medicaid programs must cover all drugs (except certain statutorily excluded drug classes) marketed by those manufacturers. In 2004 CMS estimated that 550 manufacturers participated in the Medicaid drug rebate program.[17]

For each prescription drug purchased by Medicaid, participating drug manufacturers must report two market prices to CMS—the average manufacturer price (AMP), which is the average price that drugmakers receive for sales to retail pharmacies and mail-order establishments, and the lowest transaction price, or "best price," that manufacturers receive from sales to certain private buyers of a drug. Those prices, which serve as reference points for determining manufacturers' rebate obligations, must be reported for each formulation and dosage of each prescription drug purchased on behalf of Medicaid beneficiaries.

Prescription Drug Rebates

For brand-name prescription drugs, there are two components to drug manufacturers' rebate obligations—the basic rebate and an additional rebate. The basic rebate is the greater of either 15.1% of AMP or the difference between AMP and best price. An additional rebate may also apply depending on how quickly the manufacturer raises a drug's price to private purchasers. No additional rebate is owed if the drug's current AMP does not exceed its inflation-adjusted base period level; if a drug's AMP exceeds inflation adjusted levels, then an additional rebate is owed that is equal to the excess amount. Currently, modifications to existing drugs—new dosages or formulations, such as extended release versions, sometimes referred to as product line extensions—generally are considered new products for purposes of reporting AMPs to the Secretary. As a result, drug makers can avoid incurring additional rebate obligations by making slight alterations to existing products. When new products are released, manufacturers can set their base period AMP to any price, so they are able to set new higher prices that will not incur Medicaid's additional rebates.

H.R. 3200 would clarify that prescription drug manufacturers with Medicaid pricing agreements would be required to submit AMP pricing information to the Secretary within 30 days of the end of each month of a rebate period, rather than within 30 days of the end of a rebate period. The legislation also would eliminate the requirement for the Secretary to update outpatient drug sales

[16] Federal law exempts selected purchases from Medicaid's rebate agreements, such as drugs dispensed by Medicaid managed care organizations (when prescription drugs are included in the capitation agreement), inpatient drugs, and drugs dispensed in physicians' or dentists' offices. Some states exclude or carve out drug benefits from their Medicaid managed care organization contracts, in which case, managed care beneficiaries receive their prescribed drugs through the fee-for-service delivery system, and states can claim manufacturer rebates for these purchases.

[17] Testimony of Dennis Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, before the Energy and Commerce Committee, Subcommittee on Oversight and Investigations, December 7, 2004.

made at nominal prices on a publicly accessible website. The Secretary would still be required to disclose (on a publically accessible website) AMP prices, but these would be weighted AMPs. These provisions would take effect on October 1, 2009.

H.R. 3200 also would alter the Medicaid rebate for certain extended release versions of single source drugs. Effective for drugs purchased after December 31, 2009, the rebate for extended release line extensions of single source or innovator multiple source prescription drugs that are oral solid dosage forms would be the greater of either the basic rebate or a new rebate calculation. The new rebate would be the product of (1) the AMP for the extended release formulation (in a solid dosage form) of the single source or innovator multiple source drug; (2) the highest additional rebate (calculated as a percentage of AMP) for any strength of the original single source or multiple source innovator drug; and (3) and the total number of units (as reported by a state) of each dosage form and strength of the extended release formulation that was purchased by a state during the rebate period. In addition, H.R. 3200 would increase the basic minimum rebate for single source and multiple source prescription drugs purchased under Medicaid rebate agreements from 15.1% to 22.1%.

Payments to Pharmacists

Medicaid law also requires the Secretary to establish an upper limit on the federal share of payments for prescription drug acquisition costs. These limits, referred to as federal upper payment limits (FULs) when applied to multiple source drugs, are intended to encourage substitution of lower-cost generic equivalents for more costly brand-name drugs. FULs apply to aggregate state expenditures for each drug. CMS calculates FULs and periodically publishes these prices. Under DRA, new FULs issued after January 2007 were to equal 250% of the AMP of the least costly therapeutic equivalent (excluding prompt pay discounts).[18] Manufacturers are required to report AMP to CMS.

National pharmacy associations challenged a proposed rule CMS issued in 2007 on implementation of the DRA provision covering AMP pricing. The court issued an injunction on December 19, 2007 which prohibited CMS from setting FULs for Medicaid covered generic drugs based on AMP, and from disclosing AMP data except within HHS or to Department of Justice. The 2007 injunction stands, although recently the court permitted HHS to share AMP data with the Government Accountability Office (GAO) so that GAO may study the effect on certain pharmacies of using AMP as the basis for setting FULs.

MIPPA imposed a moratorium on the use of AMP to set FULs until October 1, 2009 so that Congress could determine whether to amend the statutory definition of AMP. In the interim, FULs are set based on the pre-DRA methodology—150% of the lowest published price (i.e., wholesale acquisition cost, average wholesale price or direct price) for each dosage and strength of generic drug products.

Under H.R. 3200 , the Secretary would be required to calculate FULs at 130% of the weighted average (determined on the basis of utilization) of monthly AMPs and also would clarify that the definition of AMP excludes certain discounts and other payments.[19] H.R. 3200 also would require

[18] AMP is defined in statute to be the average price paid to the manufacturer by wholesalers for drugs distributed to the retail pharmacy class of trade.

[19] The proposed exclusions would include (1) customary prompt pay discounts paid to wholesalers; (2) bona fide service fees paid by manufacturers; (3) reimbursement from manufacturers for recalled, damaged, expired, or otherwise unsalable returned goods, including reimbursement for the cost of goods as well as handling and processing, reverse logistics, and drug destruction; (4) sales, rebates, discounts, or price concessions, paid to pharmacy benefit managers,

drug manufacturers to report within 30 days after the close of a rebate period, the manufacturer's total number of units used in calculating monthly AMPs for each covered drug. The Secretary would have authority to expedite the promulgation of regulations to clarify upper payment limit and AMP requirements and these regulations could be effective on an interim basis before a public comment period. Through December 31, 2010, states would receive federal financial participation (FFP) for multiple source drug purchases under upper limits in effect on December 31, 2006.

Extension of Prescription Drug Discounts to Enrollees of Medicaid Managed Care Organizations

States use a variety of service delivery mechanisms to provide medical and related services to Medicaid beneficiaries. Service delivery mechanisms range from full-risk capitation agreements with managed care organizations (MCOs) to fee-for-service (FFS).[20] Under full-risk capitation agreements, MCOs are paid a fixed amount for all the care Medicaid beneficiaries receive, and are responsible for all costs that exceed the fixed capitation payments. Full-risk contracts cover all medical and related services, including prescription drugs.

Drug manufacturers pay states rebates for Medicaid drug purchases, although certain purchases are excluded from the Medicaid drug rebates. Drug purchases excluded from the rebate agreements include drugs dispensed by Medicaid MCOs (when prescription drugs are included in the capitation agreement), inpatient drugs, and drugs dispensed in physicians' or dentists' offices. Some states exclude or carve out drug benefits from their Medicaid MCO contracts, in which case managed care beneficiaries receive their prescribed drugs through the FFS delivery system, and states can claim manufacturer rebates for these purchases.

H.R. 3200 would require prescription drug manufacturers to pay rebates on drugs purchased for beneficiaries covered under Medicaid managed care contracts,[21] similar to the rebates required in the FFS component of Medicaid. To help the Secretary monitor prescription drug rebates, H.R. 3200 also would require states to report quarterly their total dollar amount and volume of rebates received from prescription drug manufacturers for Medicaid beneficiaries enrolled in managed care. The reporting requirements would apply to prescription drugs dispensed beginning on July 1, 2010.

Reports on Medicaid Financing

Report on Medicaid Payments

Under current law, there are no federal requirements for states to report on a regular basis the details regarding their Medicaid payment rates to participating providers. H.R. 3200 would require new annual state reports on Medicaid payments. Each year, states would be required to provide the Secretary specific data on payment rates to providers under the state Medicaid plan,

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managed care organizations (MCOs), health maintenance organizations, insurers, mail order pharmacies not open to all members of the public, or long-term care providers, that are not passed through to retail pharmacies; (5) direct sales, rebates, discounts, or other price concessions to hospitals, clinics, or physicians unless the drugs are for inhalation, infusion, or injection or the Secretary determines under HHS procedures (which would not be subject to judicial review) that it was necessary to include the price concessions to calculate an accurate AMP for these drugs; or (6) rebates, discounts, and other price concessions required under Medicare Part D.

[20] Approximately 38% of Medicaid beneficiaries, primarily children and non-disabled adults, receive services under full risk capitation contracts.

[21] Where the health plans are responsible for prescription drugs under the managed care contracts.

including (1) final rates, (2) the methods used to determine such rates, (3) justification for those rates, and (4) an explanation of the process by which providers, beneficiaries, and other state residents have an opportunity to review and comment on such information before such rates are made final by the state.

Review of the Federal Matching Rate Formula Under Medicaid

The federal and state governments share in the cost of Medicaid benefits based on a formula that provides higher federal matching payments to states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). This formula, called the federal medical assistance percentage (FMAP), provides a minimum matching rate of 50% and a maximum matching rate of 83%. The federal matching rate for administrative services is the same for all states and is generally 50%, but certain administrative functions have a higher federal matching rate (e.g., 75% for operating a state Medicaid fraud control unit; 90% for start-up costs associated with creating a Medicaid Management Information System).

H.R. 3200 would require GAO to conduct a new study on federal matching payments made to state Medicaid programs and make recommendations regarding that formula to Congress. By February 15, 2011, GAO would be required to submit a report based on this study assessing the effect on the federal government, states, providers, and beneficiaries of making specific changes to FMAP, including (1) reducing the 50% floor or 83% ceiling, or both, and (2) revising the current FMAP formula to better reflect state fiscal capacity, state efforts to finance health and long-term care services, and to better adjust for national or regional economic downturns. GAO would also be required to study the administration of Medicaid by HHS, state Medicaid agencies, and local government agencies, and provide a report on its findings to Congress. This study would address (1) the extent to which federal funding of each administrative function is being used effectively and efficiently, and (2) the administrative functions funded with federal dollars and the expenditure amounts for each function.

Waste, Fraud, and Abuse

States are required to create a state plan for their Medicaid programs that is subject to approval by CMS. This comprehensive document describes nearly all aspects of each state's Medicaid program including administrative activities, eligibility, enrollment, covered benefits, provider credentialing, provider reimbursement, quality assurance, beneficiary cost sharing, and many more program elements. In creating their Medicaid plans, states must conform to federal rules and guidance. Whenever states make changes to their Medicaid program, they must update their state plans by submitting a state plan amendment, which is also subject to review and approval by CMS. As part of the Medicaid plan, states establish participation requirements and reimbursement rules for different providers and suppliers that deliver services to Medicaid beneficiaries, subject to federal rules. These requirements include reporting and monitoring waste, fraud, and abuse.

In general, initiatives designed to combat fraud, waste, and abuse are considered program integrity activities. This includes processes directed at reducing improper payments, as well as activities to prevent, detect, investigate, and ultimately prosecute health care fraud and abuse. More specifically, program integrity ensures that correct payments are paid to legitimate providers for appropriate and reasonable services for eligible beneficiaries. Medicaid and CHIP[22]

[22] Medicaid and CHIP program integrity are generally parallel. CHIP statute references many of the Medicaid authorities, including administrative activities, such as program integrity.

program integrity are often limited to issues of fraud and abuse by providers (as well as beneficiaries) and efforts to curtail these problems.[23]

The federal government pays a share of every state's spending on Medicaid services and program administration, including expenditures for the reduction of waste, fraud, and abuse. The federal share for most Medicaid service costs is determined by a state's FMAP. The federal match for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions have a higher federal match, including two program integrity expenditures: operation of required Medicaid Management Information Systems (MMIS) and operation of state Medicaid Fraud Control Units (MFCU). Operation of MFCUs and MMIS activities are matched at 75%, although the federal match is 90% for certain startup expenses. Thus, the federal government provides the majority of Medicaid spending to combat fraud and abuse.

Congress provided new dedicated Medicaid program integrity funding in DRA when it established a Medicaid Integrity Program (MIP) with an appropriation reaching $75 million annually for audits, identification of overpayments, education with respect to payment integrity and quality of care, and other purposes. Congress also provided in DRA an additional $25 million annually for five years beginning in FY2006 for Medicaid activities of the HHS Office of Inspector General (OIG), and an annual appropriation reaching $60 million to expand the Medicare-Medicaid data match project (referred to as Medi-Medi) that analyzes claims from both programs together in order to detect aberrant billing patterns.[24]

Improper payments are one measure of fraud and abuse activities under Medicaid. Under the Improper Payments Information Act of 2002 (IPIA, P.L. 107-300), federal agencies were required to identify programs that are susceptible to significant improper payments, estimate the amount of overpayments, and report annually to Congress on those figures and on the steps being taken to reduce such payments. In compliance with IPIA provisions, the Department of Health and Human Services estimated FY2008 Medicaid composite error rates at 10.5 percent, or $32.7 billion in improper payments of which the federal share was $18.6 billion, and, for CHIP, the rate was 14.7 percent, or $1.2 billion, with a federal share of $0.8 billion.[25]

Measures of improper payment measures focus on payments made in error, not the cause of those improper payments. Thus, improper payment measures provide no measure of fraud, which most often is undetected. Improper payment measures provide estimates of program losses in general. The National Health Care Anti-Fraud Association estimates that the losses to health insurers,

[23] For more information on Medicaid program integrity issues, see CRS Report RS22101, *State Medicaid Program Administration: A Brief Overview*

[24] The Medi-Medi program is designed to identify fraudulent or improper billing practices that affect both Medicare and Medicaid programs. By matching data across both programs, CMS investigates atypical billing patterns that may not be evident when analyzing the data from each program separately. When problems are identified, CMS works with the states to initiate payment recovery actions. CMS currently has Medi-Medi projects in 10 states and plans to expand the program nationwide.

[25] Among all federal programs reporting in FY2008, Medicaid had the highest estimated dollar value of reported improper payments, but CMS reported that the most common causes of Medicaid improper payments resulting from its medical and data processing reviews included insufficient or lack of documentation (which accounted for 90 percent of the errors), pricing errors, and non-covered services. For more discussion of improper payments, see Government Accountability Office (GAO) Testimony to the Senate Subcommittee on Federal Financial Management on April 22, 2009 at http://hsgac.senate.gov/public/_files/NewTestimonyDaly20094220.pdf.

including Medicaid, attributable to health care fraud are in the range of 3% to 10% of paid claims.[26]

Health-Care Acquired Conditions

Subject to federal rules, states generally establish their own payment policies, rates, and reimbursement methodologies for Medicaid providers, including inpatient facilities such as hospitals, nursing facilities, and intermediate care facilities for the mentally retarded. Federal regulations require that Medicaid provider rates be sufficient to enlist enough providers so that covered services are available at least to the same extent that comparable care and services are available to the general population within a given geographic area.

In Medicare, hospitals are reimbursed under a prospective payment system (PPS), where each admission is classified into a Medicare severity adjusted diagnosis-related group (MS-DRG) based on the patient's diagnosis and procedures performed. Each MS-DRG has a predetermined reimbursement amount. In general, a hospital is paid the same amount for an MS-DRG regardless of how long patients stay in the hospital or what is required to treat the patient. In some situations under Medicare's PPS, patients with certain complicating conditions could be reclassified into different MS-DRGs for which the hospital would receive a higher payment.

To avoid additional hospital payments for complications that were acquired during patients' admissions, DRA required the Secretary to initiate a hospital-acquired condition (HAC) program for Medicare.[27] Starting October 1, 2007 (FY2008), CMS required hospitals to report whether Medicare patients had certain conditions when they were admitted. Beginning October 1, 2008 (FY2009), if the HAC conditions identified by the Secretary are coded as present at admission, the conditions would not be considered to be acquired during the patient's hospital stay, and the case could receive additional MS-DRG payment. In addition to the HAC policy, in January 2009, CMS issued three national coverage determinations that precluded Medicare from paying any amount for certain serious preventable medical care errors.[28]

For Medicaid, CMS issued guidance to states in July 2008 to appropriately align Medicaid inpatient hospital payment policies with Medicare's HAC payment policies.[29] In the guidance, CMS indicated that for patients eligible for both Medicare and Medicaid (dual eligibles), hospitals that were denied payment under Medicare might attempt to bill Medicaid for HACs as the secondary payer. CMS instructed state Medicaid agencies to deny Medicaid payments when dual eligible beneficiaries had HACs during an inpatient stay. In its guidance, CMS also encouraged Medicaid agencies to implement policies that would deny payment when other (non-dual eligible) Medicaid beneficiaries had HACs during a hospitalization. CMS identified several Medicaid authorities that could be used to justify payment denials for HACs, but unlike Medicare, DRA did not specifically apply the HAC initiative to Medicaid.

[26] http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centr&wpscode=TheProblemOfHCFraud.

[27] In creating the HAC program, the Secretary was to select conditions that: (1) were high cost, high volume, or both; (2) were identified as complicating conditions or major complicating conditions; and (3) were reasonably preventable through the application of evidenced-based guidelines.

[28] These preventable errors are sometimes called "never events." Never events include surgery on the wrong body part or mismatched blood transfusions, which can cause serious injury or death to beneficiaries, and result in increased costs to the Medicare program to treat the consequences of the error.

[29] See State Medicaid Director Letter, SMDL #08-004, July 31, 2008 at http://www.cms.hhs.gov/SMDL/downloads/SMD073108.pdf

H.R. 3200 would require state Medicaid and CHIP programs to deny hospital payments for HACs as well as for certain serious preventable errors in medical care (never events) determined as non-covered by the Medicare program. In addition, states would have permission to identify other health-care acquired conditions for non-payment under Medicaid. States would be required to have these programs in place for hospital discharges that occur on or after January 1, 2010.

Evaluations and Reports Required Under Medicaid Integrity Program

Under DRA's Medicaid Integrity Program (MIP) provision, the Secretary has the authority to contract with entities to (1) conduct program integrity activities including reviewing actions of individuals and entities that furnish services under Medicaid to determine if waste, fraud, or abuse has occurred or is likely to occur; (2) audit claims for payment of services provided under a Medicaid state plan (including cost reports, consulting contracts, and risk contracts); (3) identify federal overpayments to individuals or entities; and (4) educate providers, managed care entities, and beneficiaries on program integrity and quality of care. The law established conditions that restrict entities eligible to provide MIP services and creates requirements for the Secretary to follow in contracting with eligible entities.

The Secretary was required to establish a five-fiscal year comprehensive plan for ensuring Medicaid program integrity. DRA's MIP provisions also required CMS to hire an additional 100 full-time equivalent employees who would be dedicated to Medicaid program integrity activities. The Secretary also was required to submit to Congress a report, identifying how MIP funds were spent and what MIP expenditures achieved, within 180 days of the close of each fiscal year (beginning in FY2006).

H.R. 3200 would require eligible entities (MIP contractors) to issue assurances to the Secretary that they will conduct periodic evaluations of the effectiveness of their MIP contract activities, and submit to the Secretary annual reports documenting these evaluations. This reporting requirement would be effective for each contract year beginning with 2011.

Require Providers and Suppliers to Adopt Programs to Reduce Waste, Fraud, and Abuse

Under H.R. 3200 , subject to a timeframe to be determined by the Secretary in consultation with the HHS Office of the Inspector General (OIG), state Medicaid plans must require participating providers and suppliers to establish compliance programs.[30] These compliance programs would be required to include the following core elements (1) written policies, procedures, and standards of conduct; (2) a designated compliance officer and compliance committee; (3) effective fraud, waste, and abuse training and education for an entity's employees and contractors; (4) a mechanism, such as a hotline, to report waste, fraud, and abuse that is confidential or anonymous; (5) disciplinary guidelines to enforce standards; (6) internal monitoring and auditing procedures, including contractor monitoring and auditing; and (7) procedures for ensuring prompt responses when offenses are detected, which include development of corrective action initiatives, including response to potential offenses.

The bill would permit the Secretary to give the CMS administrator authority to determine if provider and supplier compliance programs meet these requirements, and to impose civil monetary penalties up to $50,000 for violations. In addition, the Secretary may impose other

[30] The requirements in this provision would not apply to physicians and skilled nursing facilities.

sanctions on providers and suppliers, including corrective action plans and additional monitoring when violations occur.

The bill also would enable the Secretary to pilot test the compliance program requirement first on a category of Medicaid providers and suppliers that is determined to be at high risk for waste, fraud, and abuse, before requiring state Medicaid programs to require compliance programs for all providers and suppliers. H.R. 3200 also would give the Secretary the option to terminate providers or suppliers from Medicaid participation or to impose any civil monetary penalty or other intermediate sanctions if suppliers or providers fail to establish approved compliance programs.

Overpayments

Under current Medicaid law, when states discover that overpayments have been made to individuals or other entities, they have 60 days to recover or attempt to recover the overpayment before an adjustment is made to their federal matching payment. Adjustments in federal payments are made at the end of the 60 days, whether or not recovery is made. When states are unable to recover overpayments because the debts were discharged in bankruptcy or were otherwise uncollectable, federal matching payments would not be adjusted or would be readjusted in cases where the 60 day recovery deadline had passed. Beginning with enactment, H.R. 3200 would extend the period for states to repay overpayments to one year when the overpayment is due to fraud.

Managed Care Organizations

Medical loss ratio is the share of total premium revenue spent on medical claims. Medigap insurance policies are private supplemental health care policies that Medicare beneficiaries can purchase to help cover some items, services, and cost sharing not covered under Medicare. Medigap plans are required to have a minimum medical loss ratio of 65% for individual policies and 75% for group policies. In addition, some states impose medical loss ratios or related requirements on insurers in the individual and/or small group health insurance markets. As of June 2008, minimum ratios required by states ranged from 55% to 80%.

States are prohibited from making payments to Medicaid managed care organizations (MMCO) that are paid on a prepaid capitation or other risk basis unless the managed care organizations fulfill certain requirements. For instance, MMCOs are required to maintain sufficient patient encounter data to identify the physician who delivered services to Medicaid beneficiaries.

H.R. 3200 would require that no federal Medicaid and CHIP payments be made to states for expenditures incurred for services provided by certain Medicaid managed care organizations that are paid on a prepaid capitation or other risk basis (e.g., health maintenance organizations, provider sponsored organizations, other public or private organizations that meet certain requirements for written policies and procedures with respect to adult enrollees) unless the contract between the state and the entity has a medical loss ratio, as determined in accordance with a methodology specified by the Secretary, that is at least 85%. This provision also would require MMCOs to maintain and report to states patient encounter data at a frequency and level of detail to be specified by the Secretary.

Termination of Provider Participation under Medicaid and CHIP if Terminated Under Medicare or Other State Plan or Child Health Plan

Subject to certain specified exceptions, the Secretary is required to exclude from Medicare or Medicaid program participation providers that (1) have been convicted of a criminal offense related to the delivery of an item or service under Medicare or under any state health care program, (2) have been convicted, under federal or state law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service, (3) have been convicted of a felony conviction related to health care fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct, or (4) have been convicted of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

The Secretary may also exclude from Medicare or Medicaid participation providers or individuals involved in acts specifically prohibited, such as program-related convictions, license revocation, failure to supply information, and default on loan or scholarship obligations. CMS must promptly notify the Inspector General of the receipt of any application for participation that identifies any principal of a provider that has engaged in prohibited activities.

Subject to certain specified exceptions, when Medicare provider reimbursement is precluded as a result of the termination of provider participation for reasons such as those listed above, H.R. 3200 would require states to terminate federal financial participation for such providers under Medicaid and/or CHIP effective for services provided on or after January 1, 2011.

Medicaid and CHIP Exclusion from Participation Relating to Certain Ownership, Control, and Management Affiliations

Under current law, states are required to exclude providers from Medicaid and CHIP participation for reasons specified in statute (e.g., the provider is involved in criminal acts related to the program) for a specified period of time as directed by the Secretary.

H.R. 3200 would require Medicaid and CHIP state agencies to exclude individuals or entities (i.e., providers) from participating in Medicaid or CHIP if such provider owns, controls, or manages an entity that (1) has unpaid overpayments under Medicaid or CHIP or has been determined by the Secretary or the Medicaid or CHIP state agencies to be delinquent during the specified period; (2) is suspended, excluded, or terminated from participation under Medicaid or for such period; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid or CHIP participation for such period.

Requirement to Report Expanded Set of Data Elements Under MMIS to Detect Fraud and Abuse

States are required to operate an automated claims processing and information retrieval system or Medicaid Management Information System (MMIS) to administer their state plans. MMIS systems must meet a number of requirements. For example, they must (1) be compatible with Medicare claims processing and information systems, (2) provide for electronic transmission of claims data, (3) be capable of providing timely and accurate data, (4) be consistent with Medicaid Statistical Information Systems data formats, (5) meet other specifications as required by the Secretary.

H.R. 3200 would require states to submit new MMIS data as determined necessary by the Secretary for the detection of waste, fraud, and abuse under Medicaid. Such new data elements would be required on or after July 1, 2010.

Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicaid

As a condition of participation, certification, or recertification under Medicaid, the Secretary requires participating providers to supply (to the Secretary or the state Medicaid agency) information on the identity of each person with ownership or control interests in the entity or subcontractor that is equal to five percent or more of such entity. Disclosing entities include providers of service, independent clinical laboratories, renal disease facilities, managed care organizations or a health maintenance organizations, entities (other than individual practitioners or groups of practitioners) that furnish or arrange for services, carriers or other agencies or organizations that act as fiscal intermediaries or agents for service providers.

Under Medicare statute, the Secretary is required to establish a process for the enrollment of providers of services and suppliers.

The provision would require Medicaid agents, clearinghouses, or other alternate payees that submit claims on behalf of health care providers to register with the state and the Secretary in a form and manner that is consistent with the Medicare process for the enrollment of providers of services and supplies. Entities that fail to register would be denied Medicaid federal financial participation.

Denial of Payments for Litigation-Related Misconduct

States are required to deny Medicaid federal assistance payments in a number of circumstances specified in statue. Examples include, reimbursement of a nursing facility for payment of legal expenses associated with actions initiated by the facility that are dismissed because there was no basis for legal action; or reimbursement of a state for roads, bridges, stadiums, or other items not covered in a state Medicaid plan.

Under H.R. 3200, the Secretary would be required to deny payment for any amount expended on litigation in which a court imposes sanctions on a state, its employees, or its counsel for litigation-related misconduct, or for payment of legal expenses associated with any action in which a court imposes sanctions on a managed care entity for litigation-related misconduct. This provision would apply to amounts expended on or after January 1, 2010.

Mandatory State Use of National Correct Coding Initiative

CMS processes Part B Medicare claims which include payments for physician, laboratory, and radiology claims. In 1996, to help ensure correct payment for reimbursement claims, CMS implemented the correct coding initiative (CCI). Under CCI, CMS' contractors use automated pre-payment edits to review Medicare claims submitted by Part B providers. Medicare contractors use software to scan claims and apply CCI edits designed to detect anomalies that indicate a claim has incorrect information. For example, CCI edits can detect claims with duplicate services delivered to the same beneficiary on the same date of service. In addition, comparing medical billing codes CCI software can identify when medical procedure were billed erroneously as service bundles (when individual services are grouped together, but cheaper comprehensive codes are available to describe the same services) or in other cases when services should have been billed individually, but were grouped as bundled services.

H.R. 3200 would require that Medicaid claims submitted for federal reimbursement on or after October 1, 2010, would incorporate methodologies compatible with Medicare's National Correct Coding Initiative or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment. By September 1, 2010, the Secretary would be required to identify CCI methodologies (or methodologies of any successor initiative) that are compatible to claims filed under Medicaid, and identify those methodologies that should be incorporated into claims files under Medicaid with respect to items or services for which states provide medical assistance under Medicaid and no national correct coding methodologies have been established under such initiative with respect to Medicare. The Secretary also would be required to notify states of the CCI methodologies (or successor initiative) that were identified and how states should incorporate those methodologies into their Medicaid claims processing systems. The Secretary would be required to submit a report to Congress that includes the notice given to states about the CCI methodologies (or successor initiatives) and analysis that supports the identification of CCI methodologies to be applied to Medicaid claims.

Payments to the Territories

In the 50 states and the District of Columbia (hereafter referred to as the states), Medicaid is an individual entitlement. There are no limits on federal payments for Medicaid provided that the state contributes its share of the matching funds. By contrast, Medicaid programs in the five territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands) are subject to annual federal spending caps. All five territories typically exhaust their caps prior to the end of the fiscal year. Once the cap is reached, the territories assume the full costs of Medicaid services, or in some instances may suspend services or cease payments to providers until the next fiscal year.

The federal share for most Medicaid service costs is determined by the FMAP, which is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa). FMAPs have a statutory minimum of 50% and maximum of 83%. In the territories, the FMAP is typically set at 50%. Most recently, ARRA allows each territory to choose between an FMAP increase of 6.2 percentage points along with a 15% increase in its spending cap, or its regular FMAP along with a 30% increase in its spending cap for the period between the first quarter of FY2009 through the first quarter of FY2011. All five territories made the one time choice for the 30% increase in its spending cap.

The Medicaid programs in American Samoa and the Northern Mariana Islands have operated under a Section 1902(j) waiver since 1983 and 1989, respectively. Section 1902(j) refers to the section of the Social Security Act under which authority is granted to waive certain Medicaid program rules. Under a Section 1902(j) waiver, the only Medicaid requirements that may not be waived are: (1) the 50% FMAP, (2) the capped Medicaid allotments for Guam, and (3) the requirement that payment may not be made for services that are not described in Section 1905(a) of the Social Security Act.

Under H.R. 3200, for FY2011 through FY2019, the provision would increase the spending caps in the territories that are otherwise determined under current law by the following amounts (**in $ millions**):

Fiscal Year	Puerto Rico	Virgin Islands	Guam	Northern Mariana Islands	American Samoa
2011	$727.6	$34	$34	$13.5	$22

2012	$775	$37	$37	$14.5	$23.688
2013	$850	$40	$40	$15.5	$24.688
2014	$925	$43	$43	$16.5	$25.688
2015	$1,000	$46	$46	$17.5	$26.688
2016	$1,075	$49	$49	$18.5	$27.688
2017	$1,150	$52	$52	$19.5	$28.688
2018	$1,225	$55	$55	$21	$29.688
2019	$1,396	$58	$58	$22	$30.688

The provision would require that the Secretary submit a report not later than October 1, 2013, that details a transition plan to modify the existing Medicaid programs and outline actions the Secretary and the governments of each territory must take to achieve full parity in financing with the Medicaid programs with the states by FY2020. The report would be required to include FMAP rates for each territory if the formula applicable to the states were applied. The report would also be required to include any recommendations that the Secretary may have as to whether the mandatory ceiling amounts for each territory provided for in Section 1108 of the Social Security Act should be increased any time before FY2020 due to any factors that the Secretary deems relevant. The Secretary would also be required to include information about per capita income data that could be used to calculate FMAP percentages for each territory, and on how such data might differ from the per capita income data used to promulgate FMAPs for the states, as well as recommendations on how the FMAP would be calculated for the territories beginning in FY2020 to ensure parity with the states.

The Secretary would be required to submit subsequent reports to Congress in 2015, 2017, and 2019 detailing the progress that the Secretary and the governments of each territory have made in fulfilling the actions outlined to achieve Medicaid parity in financing transition plan for the territories (described above).

For fiscal years 2011 through 2019, FMAP rates for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa would be set at the highest FMAP applicable to any of the states for the fiscal year involved, taking into account the application of relevant provisions of ARRA to such states for calendar quarters during such fiscal years for which such subsections apply.

Finally, the provision would extend the waiver authority provided under Section 1902(j) to all of the territories beginning with FY2011. In addition, the Secretary would be required to provide technical assistance to the territories in upgrading their existing computer systems in order to anticipate meeting reporting requirements necessary to implement the financing parity provisions (described above), and the provision of such technical assistance would not be counted against any limitation on payment to the territories specified under Section 1108 of the Social Security Act.

Demonstrations and Pilot Programs

Medical Home Pilot Program

The concept of a medical home represents a holistic model of care which is centered around a primary care physician (PCP) or practice. This PCP is tasked with supervising and coordinating each patient's care—be it acute, chronic, or preventive. The medical home is structured so that a

PCP takes responsibility both for attending to a patient's basic care needs and for arranging and monitoring required specialty care. Moreover, the medical home presumes that physicians will be reimbursed for services which typically are not billable, such as informal counseling or the teaching of self-care techniques.

CMS is in the midst of a three-year chronic care coordination demonstration project that focuses on medical homes. Mandated by Section 204 of the Tax Relief & Health Care Act of 2006 (TRHCA, P.L. 109-432), the Medicare Medical Home Demonstration project will enlist up to eight states to provide targeted, accessible, continuous and coordinated care to Medicare beneficiaries deemed to be high need (with at least one chronic illness requiring regular medical monitoring or treatment). The demonstration aims to enroll 400 practices as medical homes and is scheduled to end in 2012, with a final evaluation due by December 2013.[31]

Like Medicare, Medicaid has limited experience with medical home pilots or programs. While there have never been national or regional medical home demonstrations or pilots under Medicaid, some federal programs designed to help fund health information technology (HIT) infrastructure have provided support for the creation of medical homes in Medicaid. First, Medicaid Transformation Grants, established by DRA, have been used by some states to provide funding for medical homes. Eight of the forty-two grants awarded in FY2007 and FY2008 were used to develop information technology infrastructure for medical home programs. Second, the Medicaid Information Technology Architecture (MITA) initiative has provided some state Medicaid agencies with federal matching funds to enhance Medicaid Management Information Systems (MMIS) capacity (P.L. 92-603). It is believed that a more flexible and fully interoperable MMIS would facilitate the creation of medical homes in Medicaid. Under the MITA initiative, states are eligible to receive a 90% federal match for the purchase/implementation of an MMIS system, and a 75% match for its maintenance. Despite the funding from MITA and the Transformation Grants, most medical home activity in Medicaid has been state-initiated and state-funded. The National Academy for state Health Policy conducted an environmental scan in June 2009 which identified 34 medical home programs, or efforts, in 31 states. Each of these seeks to establish medical homes for Medicaid or CHIP beneficiaries.

H.R. 3200 would require the Secretary to establish a five-year medical home pilot program for the Medicaid program and would authorize $1.2 billion in federal funds for such purpose. This pilot would target "high need" Medicaid beneficiaries (including medically fragile children and high-risk pregnant women). It would apply one or more of the medical home models described in section 1866E(a)(3)[32] of the Social Security Act (SSA) or any other model that the Secretary deems appropriate. The provision would waive requirements that the Medicaid medical home pilot be "in effect in all political subdivisions of the state;" or that the care provided under this pilot be qualitatively comparable (in terms of scope, quality, or duration) to care made available to other Medicaid beneficiaries who are not in the demonstration program. The pilot also would increase the matching percentage for administrative expenditures up to 90% (for the first two years of the pilot) and 75% (for the next three years). Finally, the Secretary would be required to conduct an evaluation of the pilot program.

Accountable Care Organization Pilot Program

Under H.R. 3200, the Secretary would be required to establish an accountable care pilot program under Medicaid, and would apply one or more of the models for the Medicare program also

[31] For more information on the Medicare Medical Home Demonstration, see the Fact Sheet at http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_FactSheet.pdf.

[32] See Sec. 1301 of H.R. 3200 for more information on the Medicare Accountable Care Organization Pilot.

included in this bill. Among several activities, the Medicare accountable care organizations (ACOs) would encourage the redesign of care processes, reward high-quality, efficient physician practices, and test certain payment incentive models. Qualifying ACOs would include certain physician groups, and could also include hospitals or other providers and suppliers that would share in any incentive payments. Among a number of criteria, these ACOs would have to meet certain reporting requirements and contribute to a best practices network or website to share strategies on quality improvement, care coordination and efficiency. The Medicaid ACO project would be limited to a period of five years. The Secretary would be authorized to increase federal matching rates for administrative services performed by ACOs up to 90% for the first two years and up to 75% for the remaining three years of the project. In addition, the Secretary would be required to evaluate the payment incentive model to determine its impact on beneficiaries, providers, suppliers and the overall program. An evaluation report must be reported to Congress and made available to the public.

Demonstration Project for Stabilization of Emergency Medical Conditions by Non-Publicly Owned or Operated Institutions for Mental Diseases.

Medicaid does not reimburse for treatment provided to patients receiving care in institutions for mental disease (IMD), except to those patients under age 21 receiving inpatient psychiatric care and individuals age 65 and over. IMDs are defined under Medicaid statute as hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. Federal law requires that hospital-based IMDs which have emergency departments provide a medical screening examination to individuals for whom an examination or treatment for a medical condition is requested. In such cases, the hospital-based IMD must provide for an appropriate medical screening examination to determine whether or not a medical emergency exists. If a medical emergency exists, then the hospital-based IMD must provide, within the staff and facilities available at the hospital, for further medical examination and treatment as may be required to stabilize the medical condition, or to transfer the individual to another medical facility, subject to certain limitations.

Under H.R. 3200 the Secretary would be required to establish a three-year Medicaid demonstration project in which eligible states would be required to reimburse certain IMDs that are not publicly owned or operated for services provided to Medicaid eligibles between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency medical condition. To be defined as having an emergency medical condition, an individual would have to express suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

The Secretary would be required to establish a mechanism for in-stay review to determine whether or not the patient has been stabilized. This mechanism would commence before the third day of the inpatient stay. The term “stabilized” means that the emergency medical condition no longer exists with respect to the individual and that the individual is no longer dangerous to his or her self or others.

Eligible states would be selected by the Secretary based on geographic diversity and would manage the provision of these benefits under the project through utilization review, authorization or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

Up to $75 million would be appropriated for FY2010. Such funds would remain available for obligation for three years through December 31, 2012. The Secretary would be required to allocate funds, on a quarterly basis, based on their availability and the FMAP formula.

Finally, the Secretary would be required to submit annual reports to Congress on the progress of the demonstration project as well as a final report that includes an evaluation of the demonstration's impact on the functioning of the health and mental health service system and on Medicaid enrollees. In addition, the final report would be required to contain information pertaining to whether the demonstration project resulted in increased access to inpatient mental health services under Medicaid, whether average lengths of stays for individuals admitted under the demonstration project were longer or shorter as compared to individuals otherwise admitted in comparison sites, and a state-by-state analysis of whether the project reduced emergency room visits or lengths of stay for eligibles, among other requirements. Further, the final report would be required to include a recommendation regarding whether the demonstration project should be continued after December 31, 2012, and expanded on a national basis.

Miscellaneous

Technical Corrections

Medicare Savings Programs (MSP) and Part D low-income subsidy (LIS) Programs

Federal assistance is provided to certain low-income persons to help them meet Medicare Part D premium and cost-sharing charges. To qualify for the Part D low-income subsidy (LIS), Medicare beneficiaries must have resources (assets) no greater than the income and resource limits established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). Individuals may qualify for the full subsidy in two ways: (1) if they are eligible for Medicaid or one of the Medicare Savings Programs (MSP; Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI)), or are recipients of Supplemental Security Income benefits, they are deemed automatically eligible; or (2) if they apply for the benefit through their state Medicaid agency or through the Social Security Administration (SSA) and are determined to have an annual income below 135% of the federal poverty level and to have resources below a certain limit.

The Commissioner of Social Security is required to conduct outreach efforts to identify persons potentially eligible for assistance under the MSP and the LIS programs and to notify such persons of the availability of assistance. Outreach efforts are to be coordinated with the states.

MIPPA extended the outreach requirements for the Commissioner of Social Security. Beginning January 1, 2010, the Commissioner is required, with the applicants' consent, to transmit data from the LIS application to the appropriate state Medicaid agency. The transmittal initiates an application of the individual for MSP benefits. states are required to accept data transmitted under this provision and to act on the data in the same manner and in accordance with the same deadlines as if the data constituted an initiation of an MSP application submitted directly by the individual. The date of the individual's application for LIS from which the summary data was derived constitutes the application date for MSP. Under Medicaid rules, states are required to process Medicaid applications, including MSP applications, with reasonable promptness.

H.R. 3200 would clarify that for the purpose of a state's obligation to furnish medical assistance (Medicaid-financed coverage) with reasonable promptness and for the purpose of determining when medical assistance is to be made available, the date of the electronic transmission of low-income subsidy program data to the state Medicaid Agency would constitute the date of filing for benefits under the MSP. In addition, for the purpose of determining when medical assistance will

be made available, the state would be required to consider the date of the individual's application for the LIS to constitute the date of filing for benefits under the MSP.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

CHIPRA restated prior law that federal funding for individuals who are not legal residents is not allowed, and that the law provides for the disallowance of federal funding of erroneous expenditures under Medicaid and CHIP. H.R. 3200 would make a technical correction to one sentence in CHIPRA by replacing the reference to "legal residents" with the phrase "lawfully residing in the United States." Thus, the new wording would be "Nothing in this Act allows federal payment for individuals who are not lawfully residing in the United States."

Section 1115 Waivers

Approved Section 1115 waivers are deemed to be part of a state's Medicaid (or CHIP) state plan for purposes of federal reimbursement. The provision would clarify that Medicaid coverage offered under the Special Terms and Conditions (STCs) of a Section 1115 demonstration waiver approved by the Secretary (e.g., benefit coverage, cost sharing rules, special financing arrangements, eligible populations, etc.) would be considered part of the Medicaid state plan. Medicaid program rules not explicitly listed in the waiver STCs would still apply.

Quality Measures for Maternity and Adult Health Services Under Medicaid and CHIP

CHIPRA, the reauthorization of CHIP, included several provisions designed to improve the quality of care for children under Medicaid and CHIP. The law directed to Secretary to develop (1) child health quality measures, (2) a standardized format for reporting information, and (3) procedures to encourage states to voluntarily report on the quality of pediatric care in these two programs. Examples of these initiatives included grants and contracts to develop, test, update and disseminate evidence-based measures, and demonstrations to evaluate promising ideas for improving the quality of children's health care under Medicaid and CHIP.

H.R. 3200 would require the Secretary to develop and publish measures on the quality of maternity care under Medicaid and CHIP. The Secretary would also be required to publish a standardized reporting format for these measures, to be used by participating managed care entities, providers and practitioners in reporting such measures to the Secretary. The bill would also require the Secretary to develop quality measures for services provided to adult Medicaid beneficiaries ages of 21 and 64 (that are not part of the set of quality measures for the delivery of health care services in the U.S. established under a separate provision in this bill). These measures would also be published, along with a standardized reporting format for use by participating providers. In developing these quality measures, the Secretary would be required to consult with certain academic institutions with related health quality measurement expertise, and to obtain input from stakeholders. The development of these measures must be coordinated with the development of the child health quality measures established in CHIPRA. Starting in 2013, and annually thereafter, the Secretary would be required to submit a report to Congress on the availability of reliable data relating to the quality of maternity care and services provided to adults ages 21 to 64 under Medicaid and CHIP, and recommendations for improving such quality of care under both programs. A total of $40 million would be appropriated for these activities for the five year period beginning with FY2010, to remain available until expended.

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